



Illinois State Toll Highway Authority Authorization for Release of Health Information

I, _____ *[Employee Name]*, hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to provide the information:

2. Specific person/organization (*or class of persons*) authorized to receive and use the information:

3. Specific and meaningful description of the information:

4. Purpose of the request:

5. Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the Illinois State Toll Highway Authority (ISTHA) in writing at 2700 Ogden Ave., Downers Grove, IL 60515.

I understand that the revocation is only effective after it is received and logged by ISTHA. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.
7. I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization ISTHA requests.
8. I understand that I am entitled to receive a copy of this authorization.
9. I understand that this authorization will expire when my employment with ISTHA terminates.

Signature of Employee _____ Date _____

Personal Representative Section:

If a Personal Representative executes this form, said Representative warrants that he or she has authority to sign this form on the basis of: _____.

Please return this form to the Privacy Officer, Illinois State Toll Highway Authority, 2700 West Ogden Avenue, Downers Grove, Illinois 60515.